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CONTRACTS AWARDED FOR DMEPOS CB ROUND 1 RECOMPETE PROCESS (PAGE 2)

Important ICD-10 Facts

The following is a list of important ICD-10 facts:

1.) All Health Insurance Portability and Accountability Act (HIPAA) covered entities must implement the new code sets with dates of service, or date of discharge for inpatients, that occur on or after October 1, 2014. HHS has no plans to extend the compliance date for implementation of ICD-10-CM/PCS; therefore, covered entities should plan to complete the steps required to implement ICD-10-CM/PCS on October 1, 2014.

2.) Because ICD-9-CM will no longer be maintained after ICD-10-CM/PCS is implemented, it is in non-covered entities' best interest to use the new coding system. The increased detail in ICD-10-CM/PCS is of significant value to non-covered entities. CMS will work with non-covered entities to encourage their use of ICD-10-CM/PCS.

3.) HIPAA requires the development of one official list of national medical code sets. CMS will work with State Medicaid Programs to ensure that ICD-10-CM/PCS is implemented on time.

4.) Just as an increase in the number of words in a dictionary doesn't make it more difficult to use, the greater number of codes in ICD-10-CM/PCS doesn't necessarily make it more complex to use. In fact, the greater number of codes in ICD-10-CM/PCS makes it easier for you to find the right code. In addition, just as you don't have to search the entire list of ICD-9-CM codes for the proper code, you also don't have to conduct searches of the entire list of ICD-10-CM/PCS codes. The alphabetic index and electronic coding tools are available to help you select the proper code. It is anticipated that the improved structure and specificity of ICD-10-CM/PCS will assist in developing increasingly sophisticated electronic coding tools that will help you more quickly select codes. Because ICD-10-CM/PCS is much more specific, is more clinically accurate, and uses a more logical structure, it is much easier to use than ICD-9-CM. Most physician practices use a relatively small number of diagnosis codes that are generally related to a specific type of specialty.

5.) The development of ICD-10-CM/PCS involved significant clinical input. A number of medical specialty societies contributed to the development of the coding systems.

6.) ICD-10-CM and ICD-10-PCS code books are already available and are a manageable size (one publisher's book is two inches thick). The use of ICD-10-CM/PCS is not predicated on the use of electronic hardware and software.

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Marketplace: Individual Exemptions

Starting in 2014, most people must have health coverage or pay a fee (the "individual shared responsibility payment"). You can get an exemption in certain cases. If you can afford health insurance but choose not to buy it, you must pay a fee known as the individual shared responsibility payment. The fee in 2014 is 1% of your yearly income or $95 per person for the year, whichever is higher. The fee increases every year. In 2016 it is 2.5% of income or $695 per person, whichever is higher. In 2014 the payment for uninsured children is $47.50 per child. The most a family would have to pay in 2014 is $285. You make the payment when you file your 2014 taxes, which are due in April 2015.

Under certain circumstances, you won't have to make the individual responsibility payment. This is called an "exemption." You may qualify for an exemption if you meet one of the following criteria:

1.) You're uninsured for less than 3 months of the year; 2.) The lowest-priced coverage available to you would cost more than 8% of your household income; 3.) You don't have to file a tax return because your income is too low (Learn about the filing limit; 4.) You're a member of a federally recognized tribe or eligible for services through an Indian Health Services provider; 5.) You're a member of a recognized health care sharing ministry; 6.) You're a member of a recognized religious sect with religious objections to insurance, including Social Security and Medicare; 7.) You're incarcerated, and not awaiting the disposition of charges against you; and 8.) You're not lawfully present in the U.S.

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Marketplace Exemptions

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If you have any of the circumstances below that affect your ability to purchase health insurance coverage, you may qualify for a "hardship" exemption:

1.) You were homeless; 2.) You were evicted in the past 6 months or were facing eviction or foreclosure; 3.) You received a shut-off notice from a utility company; 4.) You recently experienced domestic violence; 5.) You recently experienced the death of a close family member; 6.) You experienced a fire, flood, or other natural or human-caused disaster that caused substantial damage to your property; 7.) You filed for bankruptcy in the last 6 months; 8.) You had medical expenses you couldn't pay in the last 24 months; 9.) You experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member; 10.) You expect to claim a child as a tax dependent who's been denied coverage in Medicaid and CHIP, and another person is required by court order to give medical support to the child. In this case, you do not have the pay the penalty for the child; 11.) As a result of an eligibility appeals decision, you're eligible for enrollment in a qualified health plan (QHP) through the Marketplace, lower costs on your monthly premiums, or cost-sharing reductions for a time period when you weren't enrolled in a QHP through the Marketplace; 12.) You were determined ineligible for Medicaid because your state didn't expand eligibility for Medicaid under the Affordable Care Act.

The following methods for applying for exemptions based upon membership in a recognized religious sect whose members object to insurance, eligibility for services through an Indian health care provider, or one of the hardships described above apply:

1.) You fill out an exemption application in the Marketplace; 2.) If your income will be low enough that you will not be required to file taxes you don't need to apply for an exemption; and 3.) If you have a gap in coverage of less than 3 months, or you are not lawfully present in the U.S, you don't need to apply for an exemption. This will be handled when you file your taxes. Please visit Healthcare.gov for complete exemptions details along with more up to date information regarding the Health Insurance Marketplace.

Contract: DMEPOS Rd 1 Recompete Process

CMS recently announced the Round 1 Recompete contract suppliers for the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. This program is an essential tool to help Medicare set appropriate payment rates for DMEPOS items and save money for beneficiaries and taxpayers. Traditionally, Medicare pays for DMEPOS items using a fee schedule that is generally based on historic supplier charges from the 1980s. Numerous studies from the DHHS Office of Inspector General and the Government Accountability Office have shown these fee schedule prices to be excessive, and taxpayers and Medicare beneficiaries bear the burden of these excessive payments. The DMEPOS Competitive Bidding Program is projected to save $25.8 billion for Medicare over 10 years and save another $17.2 billion for beneficiaries through reduced coinsurance and the downward effect on premiums.

Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas. The new, lower single payment amounts resulting from the competition replace the fee schedule amounts for the bid items in these areas. The first round of the program, which went into effect in nine areas of the country on January 1, 2011, resulted in average savings of 35 percent below the fee schedule rates and has saved more than $400 million in the first two years of operation while preserving beneficiary access to quality items.

CMS is required by law to recompete contracts for the DMEPOS Competitive Bidding Program at least once every three years. The Round 1 Rebid contract period for all product categories except mail-order diabetic supplies expires on December 31, 2013. The supplier bidding period for the Round 1 Recompete concluded on December 14, 2012; the Round 1 Recompete contracts and prices are scheduled to go into effect on January 1, 2014 in the same nine competitive bidding areas as the Round 1 Rebid. The single payment amounts from the supplier competition for the Round 1 Recompete are projected to result in average savings of 37 percent as compared to the current fee schedule prices.

The Round 1 Rebid contracts and prices became effective on January 1, 2011 in the nine areas. CMS deployed a wide range of resources to monitor the program, including beneficiary surveys, active claims surveillance and analysis, contract supplier reporting, and tracking and analysis of complaints and inquiries. To date, monitoring data have shown a successful implementation with very few complaints and no negative impact on beneficiary health status. Health outcomes data is available on the CMS website at the DMEPOS FFS Health Outcomes webpage.

For the Round 1 Recompete, CMS has awarded 997 DMEPOS competitive bidding program contracts to 282 suppliers. The Round 1 Recompete suppliers have 620 locations to serve Medicare beneficiaries in these competitive bidding areas. 97 percent of contract suppliers are already established in the competitive bidding area, the product category, or both.

The bid evaluation process ensures that there will be a sufficient number of suppliers, including small suppliers, to meet the needs of the beneficiaries living in the competitive bidding areas. CMS is required to include small supplier protections for the program and instituted a 30 percent small supplier target in each competitive bidding area.

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Provider Outreach Staff:

Ceilly Robl
Phone: (303) 844-4861

John D'Alessandro
Phone: (303) 844-7095

E-mail your questions and comments to us at:
PulseofDenverRO@cms.hhs.gov

Health Insurance Marketplace: 10 Things to Tell Your Patients

1.) If you don't already have health coverage, the Health Insurance Marketplace is a new way to find and buy health coverage that fits your budget and meets your needs.

2.) Open Enrollment starts October 1, 2013, and ends on March 31, 2014. Plans and prices will be available then. Coverage starts as soon as January 1, 2014.

3.) Not only can you view and compare health insurance options online, but with one simple application, you can have those options tailored to your personal situation and find out if you might be eligible, based on your income, for financial assistance to lower your costs.

4.) The same application will let you find out if you and your family members might qualify for free or low-cost coverage available through Medicaid or the Children's Health Insurance Program (CHIP).

5.) The information is all available online, but you can apply 4 ways: online, by phone, by mail, or in-person with the help of a trained assister or navigator.

6. Each health plan will generally offer comprehensive coverage, including a core set of essential health benefits like doctor visits, preventive care, maternity care, hospitalization, prescription drugs, and more.

7.) No matter where you live, there will be a Marketplace in your state, offering plans from private companies where you'll be able to compare your health coverage options based on price, benefits, quality, and other features important to you before you make a choice.

8.) Health insurance companies selling plans through the Marketplace can't deny you coverage or charge you more due to pre-existing health conditions, and they can't charge women and men different premiums based on their gender.

9.) Marketplaces will be operated by your state, the federal government, or a partnership of the two, but each Marketplace will give you the same access to all of your Marketplace coverage options.

10.) For more information, visit HealthCare.gov. Or, call the Health Insurance Marketplace Call Center at 1-800-318-2596, 24 hours a day, 7 days a week. TTY users should call 1-855-889-4325.

Please visit the healthcare.gov website to find out how people who need health insurance can get covered.

DMEPOS Rd 1: Recompete

DMEPOS Rd 1: Recompete from Page 2

Bidders that were not offered contracts are being notified by mail of the reasons they did not qualify for the program and how they can inquire about their bid status. Suppliers that are not contract suppliers for this round of the DMEPOS Competitive Bidding Program may bid in future rounds. A list of contract suppliers is available at www.dmecompetitivebid.com. CMS' supplier locator also maintains an up to date listing of all suppliers.

The program has maintained beneficiary access to quality products from accredited suppliers in the Round 1 Rebid areas. Extensive real-time monitoring data have shown successful implementation with very few beneficiary complaints and no negative impact on beneficiary health status based on measures such as hospitalizations, length of hospital stay, and number of emergency room visits compared to non-competitive bidding areas. CMS provides a local, on-the-ground presence in each competitive bidding area through the CMS regional offices and local ombudsmen, who closely monitored implementation of the program. There is also a formal complaint process for beneficiaries, caregivers, providers, and suppliers to use for reporting concerns about contract suppliers or other competitive bidding implementation issues. In addition, contract suppliers are responsible for submitting quarterly reports identifying the brands of products they furnish, which is used to inform beneficiaries, caregivers, and referral agents. .

The Round 1 Recompete product categories include: 1.) Respiratory Equipment and Related Supplies and Accessories (oxygen, oxygen equipment, and supplies; continuous positive airway pressure (CPAP) devices and respiratory assist devices (RADs) and related supplies and accessories; and standard nebulizers); 2.) Standard Mobility Equipment and Related Accessories (walkers, standard power and manual wheelchairs, scooters, and related accessories); 3.) General Home Equipment and Related Supplies and Accessories (includes hospital beds and related accessories, group 1 and 2 support surfaces, transcutaneous electrical nerve stimulation (TENS) devices, commode chairs, patient lifts, and seat lifts); 4.) Enteral Nutrients, Equipment and Supplies; 5.)Negative Pressure Wound Therapy Pumps and Related Supplies and Accessories; and 6.) External Infusion Pumps and Supplies

A list of the specific items in each product category is available on the Competitive Bidding Implementation Contractor (CBIC) website at www.dmecompetitivebid.com. Lists of the nine Round 1 Recompete competitive bidding areas (CBAs) and the specific ZIP codes in each CBA are also available on the CBIC website.

The Scooter Store Transfers Titles to Medicare Beneficiaries

On October 24, 2013, the Delaware Bankruptcy Court approved a settlement agreement between CMS and The Scooter Store (TSS), a Medicare supplier of motorized and manual wheelchairs, and its over-50 affiliated companies. The agreement resolved CMS's Motion for Setoff filed in the bankruptcy court on September 12, 2013. TSS filed for bankruptcy on April 15, 2013.

Under the settlement, TSS will transfer title of all equipment that it has rented to Medicare beneficiaries under capped leases to an estimated 13,000 beneficiaries. Under Medicare law, title transfer for motorized wheelchairs is required after CMS makes 13 monthly payments. However, under the agreement, TSS will transfer title even if Medicare has made fewer than the 13 payments.

TSS Scooter Store is immediately sending notices to the 13,000 Medicare beneficiaries that TSS has transferred title of the equipment to them, and that they will not have make co-payments or any other payments to TSS for the remainder of the rental period for this equipment. This will also enable the beneficiaries to get any necessary Medicare- covered repairs from another Medicare supplier. TSS voluntarily agrees to terminate the participation of any of its companies in Medicare.

Preventing Marketplace Fraud

Attorney General Eric Holder, DHHS Secretary Kathleen Sebelius, and Federal Trade Commission (FTC) Chairwoman Edith Ramirez recently announced the kick off of a comprehensive interagency initiative to prevent, protect against, and, where necessary, prosecute consumer fraud and privacy violations in the Health Insurance Marketplace. The interagency officials highlighted the following new initiatives:

1.) The dedication of the Marketplace Call Center (1-800-318-2596, TTY 1-855-889-4325) as a resource and referral to FTC for consumer fraud concerns, with trained Call Center staff to effectively refer consumer threats and complaints

2.) Connecting consumers to FTC's Complaint Assistant through HealthCare.gov

3.) Development of a system of routing complaints through the FTC's Consumer Sentinel Network for analysis and referral as appropriate

4.) Establishment of a rapid response mechanism for addressing privacy or cyber security threats, and

5.) Ramping up public education to empower consumers and assisters to know the facts and avoid scams.

A fact sheet is available with tips for your patients: Protect Yourself from Fraud in the Health Insurance Marketplace. The complete press release is available and provides details regarding the initiative.

ICD-10 Facts

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7.) As with ICD-9-CM, ICD-10-CM/PCS codes should be based on medical record documentation. While documentation supporting accurate and specific codes will result in higher-quality data, nonspecific codes are still available for use when documentation doesn't support a higher level of specificity. As demonstrated by the American Hospital Association/American Health Information Management Association field testing study, much of the detail contained in ICD-10-CM is already in medical record documentation, but is not currently needed for ICD-9-CM coding.

8.) Practices may continue to create super bills that contain the most common Diagnosis Codes used in their practice. ICD-10-CM-based super bills will not necessarily be longer or more complex than ICD-9-CM-based super bills. Neither currently-used super bills nor ICD-10-CM-based super bills provide all possible code options for many conditions. The super bill conversion process includes:

-Conducting a review that includes removing rarely used codes; and

-Crosswalking common codes from ICD-9-CM to ICD-10-CM, which can be accomplished by looking up codes in the ICD-10-CM code book or using the General Equivalence Mappings (GEMs).

9.) The GEMs were not developed to provide help in coding medical records. Code books are used for this purpose. Mapping is not the same as coding as:

-Payment systems;
-Payment and coverage edits;
-Risk adjustment logic;
-Quality measures; and
-A variety of research applications involving trend data.

10.) The GEMs are a crosswalk tool that was developed by CMS and CDC for the use of all providers, payers, and data users. The mappings are free of charge and are in the public domain.

11.) As with ICD-9-CM, ICD-10-CM codes are derived from documentation in the medical record. Therefore, if a diagnosis has not yet been established, you should code the condition to its highest degree of certainty (which may be a sign or symptom) when using both coding systems. In fact, ICD-10-CM contains many more codes for signs and symptoms than ICD-9-CM, and it is better designed for use in ambulatory encounters when definitive diagnoses are often not yet known. Nonspecific codes are still available in ICD-10-CM/PCS for use when more detailed clinical information is not known.

12.) ICD-10-PCS will only be used for facility reporting of hospital inpatient procedures and will not affect the use of CPT.

Please visit the ICD-10 Facts and Myths web site for a complete breakdown of myths, facts, and

Denver Regional Office:

1600 Broadway
Suite 700
Denver, CO 80202

Phone: 303-844-2111
Fax: 303-844-3753
Email: PulseofDenverRO@cms.hhs.gov